

## 12367 CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
c. LENGTH OF STAY IN 1b 2 days				d. STREET ADDRESS 26 Harmons Ave.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl Ahalt				4. DATE OF DEATH Month 11 Day 11 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-9-57		9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY infant		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Ahalt				14. MOTHER'S MAIDEN NAME Dorothy Lidie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT James Ahalt		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atalectasis</u> 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/9/1957 to 11/11/1957, that I last saw the deceased alive on 11/11/1957, and that death occurred at 11:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. A. M. Bacon Jr.				ADDRESS (Street, city or town, state) DATE SIGNED 302 N. Potomac St. 11/12/57			
PHYSICIAN'S NAME (Type) Dr. A. M. Bacon Jr.				Hagerstown Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11-13-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR 11/14/57 24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove cotton papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2081287XV2

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint, illegible markings.

RECEIVED  
NOV 18 1967  
BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

12368

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>1 day</b>				d. STREET ADDRESS <b>817 W. Washington Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Boy Alger</b>				4. DATE OF DEATH Month Day Year <b>November 26 1957</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 24, 1957</b>	
9. AGE (In years last birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>1</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>			
13. FATHER'S NAME <b>Samuel Alger</b>				14. MOTHER'S MAIDEN NAME <b>Doris Harvey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Mr. Samuel Alger</b>				Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>anoxia</b> DUE TO <b>763.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>pulmonary congestion</b> DUE TO (c) <b>pneumonitis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 day</b> <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Nov. 25, 1957</b> to <b>Nov. 26, 1957</b> , that I last saw the deceased alive on <b>Nov. 25, 1957</b> , and that death occurred at <b>12:35 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Elaine K. Donnellan</b> M.D.				ADDRESS (Street, city or town, state) <b>131 W. Washington St. Hagerstown, Md.</b>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <b>R. Franklin Rayer</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/27/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Rayer</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Dec. 3, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Chas H. Powell</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2081271XV5

CERTIFICATE OF DEATH

RECEIVED  
DEC 5 1957  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information regarding the burial, cremation, or removal, and in any event within 72 hours after death.

12369

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg Maryland RFD 1 X2</u>	
c. LENGTH OF STAY IN 1b <u>1</u>		d. STREET ADDRESS <u>Antietam</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Edward</u> Last <u>Badger</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24 1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>10</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brakeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B &amp; O R. Road</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington County Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Zimmerman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212 14 7113</u>	
17. INFORMANT <u>Mrs. Carrie Badger</u>		Address <u>Sharpsburg Md RFD 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial asthma</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month <u>Nov.</u> Day <u>9</u> Year <u>1957</u> Hour a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>Nov. 9</u> , 19 <u>57</u> , to <u>Nov. 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 10</u> , 19 <u>57</u> , and that death occurred at <u>3:40 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter H. Shealy</u>		DATE SIGNED <u>11/12/57</u>	
PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>		ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 13-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Sharpsburg Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Williams</u>		24a. REC'D BY REGISTRAR <u>Nov 15 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Sharl. Bowers</u>			



# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. 3

NOV 18 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. This designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12370 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12365

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sharpsburg	
c. LENGTH OF STAY IN 1b 5 days		d. STREET ADDRESS Antietam Furnace	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rodney Eugene Beachley		4. DATE OF DEATH Nov. 4 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1886
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millright		10b. KIND OF BUSINESS OR INDUSTRY Furniture Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Beachley		14. MOTHER'S MAIDEN NAME Laura A. Huntsberry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No -		16. SOCIAL SECURITY NO. 214-09-2087	
17. INFORMANT Edwin C. Beachley		Address R#3 Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Acute Cerebral Hemorrhage DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S/ Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S/ Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL Burial		22b. DATE THEREOF 11-6-57	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE Nov. 7, 1957	
		24b. REGISTRAR'S SIGNATURE [Signature]	

STATE OF  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

NOV 12 1957

RECEIVED



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information regarding the burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12366

12371

# CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>10 Hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				d. STREET ADDRESS <u>2118 Virginia Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>VERNIE</u> <u>ETTA</u> <u>BECKLEY</u>				4. DATE OF DEATH Month Day Year <u>November 9 1957 19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 10 1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Kendle</u>				14. MOTHER'S MAIDEN NAME <u>Ida Crilley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Miss Ida Mae Beckley 2118 Virginia Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>155X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Gall Bladder</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hagerstown Md.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-8-57</u> , 19 <u>57</u> , to <u>11-9-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-9-57</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Hagerstown Md</u> <u>11-11-57</u> ACTUAL SIGNATURE <u>Dr. E. W. Sittler</u> M.D. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Sittler</u> <u>Hagerstown Md</u> <u>11-11-57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Nov 12 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Phyllis Powers</u>			

CERTIFICATE OF DEATH

BUREAU V. 2

NOV 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12367

Dr. L. G. Graff 12372

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>1 wk.</b>				d. STREET ADDRESS <b>120 East Antietam St.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CLYDE</b> Middle <b>MICKLEY</b> Last <b>BELL</b>				4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 15, 1895</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR: Months <b>12</b> Days <b>17</b> Hours <b>57</b> Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Williamsport, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles Bell</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Gesford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>219-05-5555</b>		17. INFORMANT <b>Benj. Tyler-Kingston, N.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Vas. Accident</b> (c) <b>Arteriosclerosis gen</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>yes</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. <b>19</b> Month, Day, Year p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Nov. 12</b> , 19 <b>57</b> , to <b>Nov 17</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 17</b> , 19 <b>57</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1195 Antietam Hagerstown, Md.</b> DATA SIGNED <b>11/18/57</b> ACTUAL SIGNATURE <b>Louis G. Graff</b> M.D. PHYSICIAN'S NAME (Type) <b>Louis G. Graff MD</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-18-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>nr. Clear Spring, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman-Hagerstown, Maryland</b>				24a. REC'D BY REGISTRAR <b>Nov 20 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>	

BUREAU V. S.

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JUN 22 1967

12373

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown	
c. LENGTH OF STAY IN 1b 5 weeks		d. STREET ADDRESS Route 40 A	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Calvin Cleveland Bierley		4. DATE OF DEATH Month 11 Day 23 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-14-1885
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY blacksmith	
11. BIRTHPLACE (State or foreign country) Funkstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William T. Bierley		14. MOTHER'S MAIDEN NAME Laura Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Mrs. Frances Potts		Address Funkstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis and Malnutrition. 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arthritis Deformans and Large decubital ulcers buttocks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 23, 1957, to Nov. 23, 1957, that I last saw the deceased alive on Nov. 23, 1957, and that death occurred at 1:20 P M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 119 N. Potomac Street		DATE SIGNED 11-25-57.	
PHYSICIAN'S NAME (Type) R.A. Bell, M.D.		Hagerstown, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-26-57	22c. NAME OF CEMETERY OR CREMATORY Funkstown	22d. LOCATION (City, town, or county) (State) Funkstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Nov. 27, 1957		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and register prior to burial, cremation, or removal, and in any event within 72 hours after death.



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NOV 29 1957

BUREAU V. I.

12374

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>Penn.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>50 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Co. Hospital</u>				d. STREET ADDRESS <u>28 N. Carlisle St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Fletcher</u> Last <u>Birner</u>				4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1883</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u>19</u> Min <u>57</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>14</u> Hours <u>19</u> Min <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Penn. Shippensburg</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Henry Fletcher</u>				14. MOTHER'S MAIDEN NAME <u>Martha Ellen Rowe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. L.H. Fletcher Birner, West Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>44-21</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic cardiovascular disease.</u> DUE TO (c) <u>stroke.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 16, 1957</u> , to <u>Nov 19, 1957</u> , that I last saw the deceased alive on <u>Nov 18, 1957</u> , and that death occurred at <u>4:51 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>154 West Washington St., Hagerstown, Md.</u> DATE SIGNED <u>11:20:57</u>							
ACTUAL SIGNATURE <u>John H. Hornbaker</u> M.D.				PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/21/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle Franklin, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stanley M. Zimmerman</u>				24. REC'D BY REGISTRAR <u>200:23/57</u>		24b. REGISTRAR'S SIGNATURE <u>Sheath Powers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12375

## CERTIFICATE OF DEATH

Reg. Dist. No.

12375

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WASH.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>6 DAYS.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSPITAL</u>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HIGHFIELD</u>		
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Joy</u> Last <u>Booth</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>6</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/21/1908</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INDUSTRIAL THERAPIST</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOSPITAL</u>		
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>		
13. FATHER'S NAME <u>ORLANDO BOOTH</u>			14. MOTHER'S MAIDEN NAME <u>ROSSETTA JOY</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>577-16-8814</u>		
17. INFORMANT <u>Mrs Harry J Booth</u>			Address <u>Highfield, Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute right heart failure</u> DUE TO <u>Chronic cat pulmonale</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis of coronary arteries</u> DUE TO <u>Pulmonary fibrosis - healed tuberculosis</u> (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 wk -</u> <u>at least 2 yrs -</u> <u>Unknown -</u> <u>Several years -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute gastro-enteritis</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>10/31</u> , 19 <u>52</u> , to <u>11-6-57</u> , that I last saw the deceased alive on <u>11-6-1957</u> , and that death occurred at <u>7:15 A.M.</u> , from the causes and on the date stated above					
ACTUAL SIGNATURE <u>John H Hornbaker</u>			ADDRESS (Street, city or town, state) <u>154 West Washington St., Hagerstown, Md.</u>		
PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>			DATE SIGNED <u>11-6-57</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/8/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>	22d. LOCATION (City, town, or county)	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Davis</u>			24a. REC'D BY REGISTRAR <u>Walter J. Davis</u>		
ADDRESS <u>Haymarket, Pa.</u>			24b. REGISTRAR'S SIGNATURE <u>Walter J. Davis</u>		
DATE <u>Nov 9, 1957</u>					

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12376

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12376 CERTIFICATE OF DEATH

12371  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>8 YEARS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>651 POINT SALEM ROAD</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>651 POINT SALEM ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRED LAFAYETTE BROWN</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 1 1957 19</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 9 1896</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TOOL CUSTODIAN FAIRCHILD AIRCRAFT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CLEVELANDVILLE WASH.CO.MD. U.S.A.</b>	
11. BIRTHPLACE (State or foreign country) <b>CLEVELANDVILLE WASH.CO.MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN BROWN</b>		14. MOTHER'S MAIDEN NAME <b>IDA BROWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220 10 3930</b>	
17. INFORMANT <b>MRS. ZELLA BROWN</b>		18. HAGERSTOWN MD. <b>651 POINT SALEM ROAD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart disease and</b> <b>420.0</b> DUE TO <b>Coronary Thrombosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <b>None.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 4, 1957</b> to <b>Oct. 18, 1957</b> , that I last saw the deceased alive on <b>October 18, 1957</b> , and that death occurred at <b>11:00 A.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>119 North Potomac Street</b> DATE SIGNED <b>11-2-57</b> ACTUAL SIGNATURE <b>R. A. Bell</b> M. D. PHYSICIAN'S NAME (Type) <b>R. A. Bell, M. D.</b> <b>Hagerstown, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. 4 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY BOONSBORO WASH.CO.MD.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul Paul House Boonsboro Md</b>		24a. REC'D BY REGISTRAR <b>Nov. 6, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Chas. H. Pomeroy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 1944

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12377 CERTIFICATE OF DEATH

12372

Reg. Dist. No. 302

1. PLACE OF DEATH o COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>301 N. Mulberry St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ANNA</b> First <b>MAY</b> Middle <b>BRUNNGRABER</b> Last		4. DATE OF DEATH Month <b>November</b> Day <b>9</b> Year <b>1957</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 1, 1892</b>		9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>10</b> Days <b>8</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hagerstown, Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Rowland</b>				14. MOTHER'S MAIDEN NAME <b>Hattie Lumm</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Fred C. Brunngraber</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic Heart Disease</b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>57 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ulcer of stomach</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour o m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 8</b> , 19 <b>57</b> , to <b>Nov 9</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov 9</b> , 19 <b>57</b> , and that death occurred at <b>3:20 P.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Siding Hoveston, Md.</b>				DATE SIGNED <b>11-9-57</b>			
ACTUAL SIGNATURE <b>SIDNEY HOVESTON</b>				PHYSICIAN'S NAME (Type) <b>SIDNEY HOVESTON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/12/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Houser</b>				24a. REC'D BY REGISTRAR <b>Nov. 13, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Frank Houser</b>	

BUREAU V. S.

NOV 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Form G222, 11/15/57 for

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

12373

12378

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES LOUIS BUSKEY</b>				4. DATE OF DEATH Month Day Year <b>November 7 1957</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>September 7, 1911</b>	
9. AGE (In years last birthday) <b>46 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>2 0</b>		IF UNDER 24 HRS <b>0</b>			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>			
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Louis F. Buskey</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>212-01-3929</b>		17 INFORMANT <b>Louis F. Buskey</b> Address <b>Baltimore, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>hypoxia</b> DUE TO <b>bronchial pneumonia &amp; asthma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>several days</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Nov 1, 1957</b> , to <b>Nov 18, 1957</b> , that I last saw the deceased alive on <b>Nov 7, 1957</b> , and that death occurred at <b>2 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>136 N. Potomac St. Hagerstown</b> DATE SIGNED <b>11/15/57</b>							
ACTUAL SIGNATURE <b>Howard N. Weeks</b> M.D.				PHYSICIAN'S NAME (Type) <b>Howard N. Weeks</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11/11/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Super-Rouzer Funeral Home</b> ADDRESS <b>Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>Nov 18, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>	



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BUREAU V. 31

12429

## CERTIFICATE OF DEATH

12374

Reg. Dist. No. 367

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>MARYLAND</b> <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROHRERSVILLE RURAL</b>		c. LENGTH OF STAY IN TB <b>8 MONTHS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROHRERSVILLE RURAL</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ROHRERSVILLE MD.</b>				d. STREET ADDRESS <b>ROHRERSVILLE MD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>T.</b> Last <b>BUSSARD</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>2</b> Year <b>1957</b>			
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>DECEMBER 28 1876</b>		9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSE BUILDER</b>		11. BIRTHPLACE (State or foreign country) <b>NR. KEEDYSVILLE WASH. CO. MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JOHN BUSSARD</b>				14. MOTHER'S MAIDEN NAME <b>MARY BUSSARD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. KENNETH STANGLE ROHRERSVILLE MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>General arteriosclerosis</b> DUE TO General arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>5 Yrs</b> <b>10 Yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 30, 1957</b> , to <b>-----</b> , 19 <b>-----</b> , that I last saw the deceased alive on <b>Oct. 30, 1957</b> and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sharpburg, Md.</b> DATE SIGNED <b>11/2/57.</b>							
ACTUAL SIGNATURE <b>Walter H. Shealy</b> M.D. <b>Sharpburg, Md.</b> DATE SIGNED <b>11/2/57.</b>							
PHYSICIAN'S NAME (Type) <b>Walter H. Shealy M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL NOV. 5 1957</b>		22b. DATE THEREOF <b>NOV. 5 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. VIEW CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>SHARPSBURG WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Hove</b>				24a. REC'D BY REGISTRAR DATE <b>Nov 5, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Katherine Dagenhart</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 6 1957

RECEIVED

## 12379 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>38 North Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>JOHN</u> Last <u>CALLAS</u>				4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 15, 1886</u>	
9. AGE (In years last birthday) <u>71 yrs.</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>21</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Callas</u>				14. MOTHER'S MAIDEN NAME <u>Maria Papapanos</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Michael G. Callas</u> Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tumor of Mediastinum - type (?)</u> <u>231X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>11</u> Day <u>8</u> Year <u>1957</u> Hour <u>a. m.</u> p. m. <u></u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>57</u> , to <u>Nov. 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 5</u> , 19 <u>57</u> , and that death occurred at <u>4:10 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>214 N. Potomac St Hagerstown, Md.</u> DATE SIGNED <u>11/7/57</u>							
ACTUAL SIGNATURE <u>Lloyd A. Hoffmann</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffmann</u> <u>Hagerstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/8/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>R. S. Rouzer</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov 8, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>			

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

3. REGISTRAR: This certificate should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V

NOV 12 1956

RECEIVED



12380 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>3 Hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sh. County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALDA GRACE CARPER</u>				4. DATE OF DEATH Month Day Year <u>November 7 1957 19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 7 1899</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles E. Carper</u>				14. MOTHER'S MAIDEN NAME <u>Bernice Marker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u> (If yes, give war or dates of service) <u>----</u>				16. SOCIAL SECURITY NO <u>814-09-9103</u>			
17. INFORMANT <u>Miss Myrtle Carper</u>				Address <u>101 Bellview Ave Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Nov 6</u> , 19 <u>57</u> , to <u>Nov 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 7</u> , 19 <u>57</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. F. Lusby</u>				ADDRESS (Street, city or town, state) <u>230 N Potomac</u>		DATE SIGNED <u>8 Nov 57</u>	
PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>				<u>Hagerstown Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Hebron Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Winchester Fred. Co Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Eoffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Nov 12/1957</u> 24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>	

BUREAU V. S.

NOV 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12377

Dr. E. W. Ditto III 12381

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>728 West Washington St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>LUTHER HAUER CORDERMAN</b>				4. DATE OF DEATH Month Day Year <b>November 4 19 57</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 1, 1878</b>		
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown-Wash. Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Martin L. Corderman</b>				14. MOTHER'S MAIDEN NAME <b>Maryland Margaret Hauer</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-28-5388</b>		17. INFORMANT <b>Ernest W. Corderman-419 W. Wilson Blvd.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of prostate with</b>							<b>1 yr</b>	
DUE TO							<b>ok</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							<b>less</b>	
(b) <b>metastases to pelvis and</b>								
DUE TO								
(c) <b>probable metastases to spinal cord</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>general arteriosclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
				20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <b>OCT 25, 1952</b> , to <b>Nov. 4, 1957</b> , that I last saw the deceased alive on <b>Nov 4</b> 19 <b>57</b> , and that death occurred at <b>11:38</b> M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Edward W. Ditto III</b> M.D.				ADDRESS (Street, city or town, state) <b>217 W. Washington Street</b>				
DATE SIGNED <b>11-7-57</b>								
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, D. Hagerstown, Maryland</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-7-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dunkard Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Broadfording-Wash. Co., Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman-Hagerstown, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>11/8/57</b>		
						24b. REG. STRAR'S SIGNATURE <b>Chas. H. Bowers</b>		

RECEIVED

NOV 12 1957

BUREAU V. S.

## 12382 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>2 years</b>				d. STREET ADDRESS <b>829 Concord Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>829 Concord Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Joanna</b>		First <b>Agnes</b>		Middle <b>Christ</b>		Last	
4. DATE OF DEATH Month <b>November</b>		Day <b>10</b>		Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1876</b>	9. AGE (in years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>15</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Martinsburg, W. Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Michael Goheen</b>				
14. MOTHER'S MAIDEN NAME <b>Ellen Sullival</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>no</b>				
16. SOCIAL SECURITY NO. <b>none</b>			17. INFORMANT <b>Mrs. A. D. Keller Hagerstown, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with old coronary occlusion</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>chronic cholecystitis &amp; cholelithiasis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 5, 1955</b> to <b>Nov. 8, 1957</b> , that I last saw the deceased alive on <b>Nov. 10, 1957</b> , and that death occurred at <b>6:15</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edward W. Ditto III</b> M.D.				ADDRESS (Street, city or town, state) <b>217 W. Washington Street</b>			
DATE SIGNED <b>11/11/57</b>							
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III</b> <b>217 W. Wash. St. Hagerstown, Md.</b>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/12/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Martinsburg, W. Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Renger</b> Suter-Rouzer Funeral Home				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>11/13/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>			

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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NOV 15 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information regarding the death, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12379

CERTIFICATE OF DEATH

Reg. Dist. No.

302

12383

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>70 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Convalescent Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROGER</b> Middle <b>ELLSWORTH</b> Last <b>DAVIS</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>21</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 16 1887</b>	
9. AGE (In years last birthday) <b>70 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sole stitcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Mfg. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>J William Davis</b>			
14. MOTHER'S MAIDEN NAME <b>Alice Cruzon</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>214 99-5366A</b>				17. INFORMANT <b>Mrs. Richard J Hamilton</b> Address <b>Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiovascular</b> <b>177.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>5 m.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Malnutrition</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month _____ Day _____ Year <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <b>1897</b> , 19 <b>17</b> , to <b>21 Nov</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>19 Nov</b> , 19 <b>57</b> , and that death occurred at <b>5:10 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edwin D. H. ...</b> M.D.				ADDRESS (Street, city or town, state) <b>111 W. West</b>		DATE SIGNED <b>11/22</b>	
PHYSICIAN'S NAME (Type) <b>Edwin D. H. ...</b>				22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
22b. DATE THEREOF <b>11/23/57</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown</b> (State) <b>Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer</b> ADDRESS <b>Funeral Home</b>				24a. REC'D BY REGISTRAR <b>Nov. 26, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Thad. H. Bowers</b>	

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NOV 2 1957

BUREAU A



## CERTIFICATE OF DEATH

Reg. Dist. No.

302

12334

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>Delaware</b> b. COUNTY <b>Newcastle</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wilmington</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>	
d. STREET ADDRESS <b>507 N. Bancroft Pkwy</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>Edward</b> Last <b>Deats</b>		4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22, 1887</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR: Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min. <b>69</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Wilmington Del.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Del.</b>	
13. FATHER'S NAME <b>Theodore Deats</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Bowers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Robert J. Gamble</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>infection.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary edema.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 Nov. 1957</b> to <b>1 Nov. 1957</b> , that I last saw the deceased alive on <b>1 Nov. 1957</b> , and that death occurred at <b>4:45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1135 Potomac Ave. Hag. Md.</b> DATE SIGNED <b>Dr. Richard T. Binford</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11-5-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wilmington Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>Nov. 5, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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NOV 7 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12381

Dr. P. J. Hirshman 12385 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 week</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>23 Hagerstown</b>	
f. STREET ADDRESS <b>38 Glenside Ave.</b>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARRIE ELIZABETH DIFFENDALL</b>		4. DATE OF DEATH Month Day Year <b>November 25, 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1878</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter Frebert</b>		14. MOTHER'S MAIDEN NAME <b>Betty Tully</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Patrick H. Diffendall</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Arteriosclerosis + Hypertensive Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 29, 1956</b> to <b>Nov. 25, 1957</b> , that I last saw the deceased alive on <b>Nov. 25, 1957</b> , and that death occurred at <b>3:15 P.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>159 W. Washington St. Hagerstown Md. 11/26/57</b>	
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-29-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Winters Lutheran Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>New Windsor-Carroll Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman-Hagerstown, Maryland</b>		ADDRESS <b>24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE</b> <b>Nov. 29, 1957 John H. Bowers</b>	

RECEIVED  
JUN 10 1947  
BUREAU OF

## 12386 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution, residence before admission] a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 60 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) GARLOCK CONV. MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EMMA M. DITMER				4. DATE OF DEATH NOVEMBER 10 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/25/1866	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN KUNKLE				14. MOTHER'S MAIDEN NAME ? WOLF			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE		17. INFORMANT MR. EARL S. DITMER HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anteroselective Heart Disease 1450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year 19 57 Hour a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) HAGERSTOWN				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from March 19 54 to Nov. 9 19 57 that I last saw the deceased alive on May 1 19 57, and that death occurred at 12:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE D. J. BOYER, M. D.				ADDRESS (Street, city or town, state) 135 W. Polomoe St. DATE SIGNED 11/12/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 11/13/57		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	
22d. LOCATION (City, town, or county) HAGERSTOWN				22e. (State) MD.			
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Harwood, Hagerstown, Md.				24a. REC'D BY REGISTRAR Nov. 14, 1957		24b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

NOV 3 57

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12383

12430

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairplay Md.</b>		c. LENGTH OF STAY IN 1b <b>15 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairplay Maryland</b>		d. STREET ADDRESS <b>Fairplay Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fairplay Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Della</b> Last <b>Downs</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>10</b> Year <b>1957</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 31 1874</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>9</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Rockdale Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Leshner</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ellen Stine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mrs. Lewis Rice</b>		Address <b>Fairplay Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>120.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerosis - General.</b> DUE TO (c) <b></b>			
INTERVAL BETWEEN ONSET AND DEATH <b>4 yr +</b> <b>Yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cholecystitis - chronic</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec.</b> 1956, to <b>NOV. 10</b> , 1957, that I last saw the deceased alive on <b>NOV 10</b> , 1957, and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>214 N. Potomac st.</b> DATE SIGNED <b>11/11/57</b>			
ACTUAL SIGNATURE <b>Chas C. Hoffman</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b> <b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 13-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Iverview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert Leaf</b> <b>Williamsport, Md.</b>			
24b. REC'D BY REGISTRAR <b>John H. Best</b>		24c. REGISTRAR'S SIGNATURE <b>John H. Best</b>	

BUREAU V. S.

NOV 17 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.  
REGISTRAR: This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

State of Maryland DEPARTMENT OF HEALTH—BALTIMORE, 18

12384

814 West Wells, M.D. D.M.E.  
Nov. 27-57

# CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>4 years</u>		d. STREET ADDRESS <u>239 North Potomac Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>239 North Potomac Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Kate</u> Middle <u>M.</u> Last <u>Dyche</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1870</u>
9. AGE (In years last birthday) <u>87 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Berkeley Co. W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Ream</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Landis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Catherine Dyche, Hagerstown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>malnutrition &amp; anemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>7/23/56</u> , 19____, to _____, 19____, that I last saw the deceased alive on <u>4/23/57</u> , 19____, and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		ADDRESS (Street, city or town, state) <u>133 North Potomac Street</u> DATE SIGNED <u>11/25/57</u>	
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-26-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenway Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Berkeley Spring, W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Bunker Berkeley Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 27, 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>	

REAU V. S.

1957

3

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12431 CERTIFICATE OF DEATH

Reg. Dist. No.

12385

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Shenandoah</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport RFD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edinburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Honewood Church Home</u>		d. STREET ADDRESS <u>None</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>MARTHA ELLEN ECKSTINE</u>		4. DATE OF DEATH Month Day Year <u>Nov 30 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Shenandoah Co Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Miller</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Bowers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>John J. Eckstine</u>		Address <u>9820 Colesville Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Thrombotic stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic hypertension</u> (c) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-1-1957</u> to <u>11-24-57</u> , that I last saw the deceased alive on <u>11-24-57</u> , and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Edinburg Shenandoah Co Va.</u> DATE SIGNED <u>Nov 30 1957</u>			
ACTUAL SIGNATURE <u>John J. Eckstine</u> M.D.			
PHYSICIAN'S NAME (Type) <u>John J. Eckstine</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lt Zion Luth. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Edinburg Shenandoah Co Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>CLC</u>		24b. REGISTRAR'S SIGNATURE <u>Emma McElroy</u>	

RECEIVED

DEC 4 1957

BUREAU V. S.

12432

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12386

Reg. Dist. No. 361

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>		c. LENGTH OF STAY IN 1b <b>83 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>127 S. Artizan Street</b>				d. STREET ADDRESS <b>127 S. Artizan Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Issac</b> Middle <b>Snivley</b> Last <b>Motter</b> <b>Faughander</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>25</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1 1874</b>		9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>23</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Card Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Western Md. Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Williamsport Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Faughander</b>				14. MOTHER'S MAIDEN NAME <b>Annie Grosh</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>705 10 5014</b>		17. INFORMANT <b>Mr. Hugh M. Faughander</b> Address <b>20 S. Montvalla Hagerstown Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Vascular Hypertension</b> DUE TO <b>arterio cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <b></b> DUE TO <b></b> (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b></b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>Nov. 26-57</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 29-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Leaf Williamsport, Md</b>				24a. REC'D BY REGISTRAR <b>Nov 26 1957</b>		24b. REGISTRAR'S SIGNATURE <b>E. Lee McElroy</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

EDWARD V. S.

670

RECEIVED

*County of* **MARYLAND** **DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

Reg. Dist. No. **3**

**123873**

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLEAR SPRING RT 1</b>		c. LENGTH OF STAY IN b. <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FAIRVIEW ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>ALSTON</b> Last <b>FIERY SR.</b>		4. DATE OF DEATH Month <b>11</b> Day <b>11</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 29, 1974</b>
9. AGE (In years last birthday) <b>83</b> yrs		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAUEL FIRBY</b>		14. MOTHER'S MAIDEN NAME <b>ANNE SPIGLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>16-10-4266A</b>	
17. INFORMANT <b>S. LENA FIRBY</b>		Address <b>CLEAR SPRING, D.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 11, 1957</b> , to <b>Nov. 11, 1957</b> , that I last saw the deceased <b>DEAD</b> on <b>NOVEMBER 11, 1957</b> , and that death occurred at <b>12-30 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Archie Robert Cohen</i> M.D.		ADDRESS (Street, city or town, state) <b>CLEAR SPRING, MARYLAND</b> DATE SIGNED <b>11-12-57</b>	
PHYSICIAN'S NAME (Type) <b>ARCHIE ROBERT COHEN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/13/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT. TABOR CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>WASHINGTON CO. MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Clark</b>		24a. REC'D BY REGISTRAR DATE <b>Nov 15 57</b>	24b. REGISTRAR'S SIGNATURE <i>Joseph W. Newkay</i>

RECEIVED  
NOV 18 1957  
BUREAU V. S.



Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Washington</u>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Nora</u> Last <u>Fleming</u>		4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>1957</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov 5, 1865</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>24</u> Hours <u></u> Min. <u></u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Shepherdstown, W. VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Joseph Fleming</u>		14 MOTHER'S MAIDEN NAME <u>Catherine Hawn</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>None</u>	
17 INFORMANT <u>Miss Mary Fleming</u>		23 W. <u>Salisbury St.</u> <u>Williamsport Md.</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Asphyxial</u> 492 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Hour <u>o. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u> p. m. <u></u>		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/30</u> , 19 <u>53</u> to <u>Nov 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 26</u> , 19 <u>57</u> , and that death occurred at <u>1:30 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Haak</u>		DATE SIGNED <u>29 Nov</u>	
PHYSICIAN'S NAME (Type) <u>Paul Haak</u>		<u>Williamsport, Md.</u>	
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 30-57</u>	
22c NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d LOCATION (City, town, or county) (State) <u>Williamsport, Maryland</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Albert J. ...</u>		ADDRESS <u>Williamsport Md.</u>	
24a REC'D BY REGISTRAR DATE <u>Nov 27 1957</u>		24b REGISTRAR'S SIGNATURE <u>...</u>	

THOMAS V. S.

DEC 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12388 CERTIFICATE OF DEATH

Reg. Dist. No.

12389  
302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>931 Corbett St.</b>				d. STREET ADDRESS <b>931 Corbett St.</b>			
3. NAME OF DECEASED (Type or print) First <b>IRENE</b> Middle <b>MARY</b> Last <b>GROVE</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>26</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 16, 1899</b>		9. AGE (In years last birthday) <b>58 yrs</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Warren, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Ja mes Arthur Vance</b>				14. MOTHER'S MAIDEN NAME <b>Theadoshia Colwell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Margie Alexander 931 Corbett St. Hagerstown, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous Cell Carcinoma of</b> <b>146X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>larynx - pharynx</b> DUE TO (c) <b>146X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>14 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 2, 1957</b> to <b>Nov 25, 1957</b> , that I last saw the deceased alive on <b>Nov. 25, 1957</b> , and that death occurred at <b>6:25 M.</b> from the causes and on the date stated above. <b>Edward W. Ditto</b> ADDRESS (Street, city or town, state) <b>M.D. 217 W. Washington St. Hagerstown, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>E.W. Ditto III</b> M.D. <b>217 W. Washington St. Hagerstown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/29/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. 1601 Penna. Ave. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>200.29.1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phas H. Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JUN 2 1957  
BUNNELL V. E.

12389

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>45 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>930 Oak Hill Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF <u>Harry</u> First <u>Jacob</u> Middle <u>Hamilton</u> Last (Type or print)				4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 24, 1892</u>		9. AGE (In years last birthday) <u>65</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Package Store</u>		11. BIRTHPLACE (State or foreign country) <u>Near Waynesboro Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Andrew Hamilton</u>				14. MOTHER'S MAIDEN NAME <u>Annie Sprecher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>218-30-9180</u>		17. INFORMANT <u>Mrs. Nellie J. Hamilton Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.1</u> DUE TO <u>arteriosclerotic coronary heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>coronary thrombosis</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2yrs</u> <u>2yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1952</u> , to <u>Nov. 12, 1957</u> , that I last saw the deceased alive on <u>Nov. 1, 1957</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>115 N. Potomac St. Hag. Md.</u> DATE SIGNED <u>S. Robert Wells</u> ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D. <u>115 N. Potomac St. Hag. Md.</u> PHYSICIAN'S NAME (Type) <u>Dr. Samuel R. Wells</u> <u>Hagerstown, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Linnich &amp; Son</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>11/16/1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. H. Bowers</u>			

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

REGISTRAR: 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

BUREAU V. 2

NOV. 19 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12435 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12391  
304

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock, Md.</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>153 West Main Street</b>				d. STREET ADDRESS <b>153 West Main Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>Elwood</b> Last <b>Heller</b>				4. DATE OF DEATH Month <b>November</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/19/1890</b>		9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b>	IF UNDER 24 HRS. Hours <b>57</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bank Teller</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bank Teller</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry F. Heller</b>				14. MOTHER'S MAIDEN NAME <b>Fannie E. Murray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>World War 1 212-14-6041</b>		17. INFORMANT Address <b>Mrs. Bertha Heller Hancock, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Advanced arteriosclerotic coronary heart disease ( angina )</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) <b>Hancock</b>		(County) <b>Washington</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-10-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Preshelton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hancock Md Washington</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Stone Hancock Md</b>				24a. REC'D BY REGISTRAR <b>11-10-57</b>		24b. REGISTRAR'S SIGNATURE <b>J. A. Neller</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

NOV 19 1957

BUREAU V. S.



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12390

CERTIFICATE OF DEATH

12392

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>31 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1853 Virginia Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROSE</b> Middle <b>SCHNEBLEY</b> Last <b>HICKS</b>				4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 12, 1870</b>	
9. AGE (In years last birthday) <b>87 yrs</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>17</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Clearspring District, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Troupe</b>				14. MOTHER'S MAIDEN NAME <b>Ann Catherine Schnebley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Frederick D. Eyster Frederick Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Vascular Disease</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 1/2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <b></b> o. m. <b></b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1955</b> to <b>NOV. 29, 1957</b> , that I last saw the deceased alive on <b>NOV. 28, 1957</b> , and that death occurred at <b>8:05 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>214 N. Potomac St. Hagerstown, Md.</b> DATE SIGNED <b>11/30/57</b>							
ACTUAL SIGNATURE <b>Lloyd A. Hoffman</b>				PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/2/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>St. Paul's Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Franklin Boyer</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Dec 3, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Wm. H. Boward</b>	

RECEIVED V. S.

RECEIVED

## 12391 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Maryland</b>				c. LENGTH OF STAY IN 1b <b>Life time</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>409 North Jonathan Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Charles Benjamin Hill</b>				4. DATE OF DEATH Month Day Year <b>Nov 24 1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 28 1869</b>		9. AGE (In years last birthday) <b>88 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private family</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Richard Hill</b>				14. MOTHER'S MAIDEN NAME <b>Anna Dorsey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] <b>no</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT Address <b>Mrs Madge Hicks 409 N. Jonathan St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-vascular Disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Nov. 15 - 1957</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m.	Month. Day. Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>Feb 28</b> , 1956, to <b>Nov 24</b> , 1957, that I last saw the deceased alive on <b>Nov. 24</b> , 1957, and that death occurred at <b>1:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Sidney Novenstein M.D. Furlow Lane Md 11-26-57</b>							
ACTUAL SIGNATURE <b>SIDNEY NOVENSTEIN</b>		PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-27-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John R Watson of Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>Nov 27 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Shirley Bowers</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

27 - 1 1957

BUREAU V. E.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12436

## CERTIFICATE OF DEATH

12394

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Hook</b>				c. LENGTH OF STAY IN 1b <b>20 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LEWIS</b> Middle <b>MARIAN</b> Last <b>HOFFMAN</b>				4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 31, 1877</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Harpers Ferry, W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Frederick Hoffman</b>			
14. MOTHER'S MAIDEN NAME <b>Eugenia Smith</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>Unknown</b>				17. INFORMANT <b>Mrs. Bertha K. Hoffman</b> Address <b>RED # 1, Knoxville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) Interval between onset and death <b>4-5 days</b> Unknown						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Atrophic Arthritis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Charles Town, West Va.</b>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>D.O.A.</b> 19____, to____, 19____, that I last saw the deceased alive on____, 19____, and that death occurred at <b>2:22A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Nov. 18, 1957</b> DATE SIGNED ACTUAL SIGNATURE <b>Mildred Williams</b> M.D. NAME (Type) <b>Dr. Mildred Williams</b> <b>Charles Town, West Va.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/18/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Harper Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Harpers Ferry, West Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Donald Eacker</b> ADDRESS <b>Harpers Ferry, W. Va.</b>				24a. REC'D BY REGISTRAR <b>Nov. 19/57</b>		24b. REGISTRAR'S SIGNATURE <b>Katherine Kaguehart</b>	

RECEIVED

NOV 20 1957

BUREAU V. S.

## 12437 CERTIFICATE OF DEATH

Reg. Dist. No. 381

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport Md RFD 1</b>				c. LENGTH OF STAY IN 1b <b>5 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pinesburg</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport Maryland RFD 1</b>			
f. STREET ADDRESS <b>Pinesburg</b>				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Myers</b> Last <b>Hoffman</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>3</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 10 1890</b>	9. AGE (In years last birthday) <b>66 yrs</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>23</b> Hours <b></b> Min <b></b>		IF UNDER 24 HRS. Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Franklin Co. Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Clinton Hoffman</b>				14. MOTHER'S MAIDEN NAME <b>Alice Myers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215 36 5894</b>		17. INFORMANT <b>Mrs. Eva Hoffman</b> Address <b>Pinesburg Md Williamsport Md RFD 1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4-10-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>				INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>	Month <b></b> Day <b></b> Year <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>11/3/57</b> , 19 <b>57</b> , to <b>11/3/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/3/57</b> , 19 <b>57</b> , and that death occurred at <b>6:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town state) <b>Williamsport, Md</b> DATE SIGNED <b>11/4/57</b>							
ACTUAL SIGNATURE <b>Edith V. Leaf</b> M.D.		PHYSICIAN'S NAME (Type) <b>Edith V. Leaf</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 6-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edith V. Leaf</b> ADDRESS <b>Williamsport Md</b>				24a. REC'D BY REGISTRAR <b>Nov 5-57</b>		24b. REGISTRAR'S SIGNATURE <b>E Lee McElroy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 9 1977

RECEIVED



12438

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item in File 3222 11-25-57 at

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN RT 4</b>		c. LENGTH OF STAY IN 1b <b>61 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HAGERSTOWN RT 4</b>				d. STREET ADDRESS <b>HAGERSTOWN RT 4</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>SCOTT</b> Last <b>IRVIN</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>9</b> Year <b>19 57</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 24, 1896</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL IRVIN</b>				14. MOTHER'S MAIDEN NAME <b>Alice Marie Switcher</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-12-1098</b>		17. INFORMANT <b>PERCY IRVIN HAGERSTOWN RT 4 MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asian Flu</b> <b>4 x / x</b> DUE TO <b>Broncho-pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Asthma</b>							INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>5 days</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>None</b> 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) <b>-</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/12/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BLAIRS VALLEY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Clark Clear Spring, Md.</b>				24a. REC'D BY REGISTRAR <b>Nov 15 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Leroy M. Fochler</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
NOV 20 1957  
BUREAU V. E.

Dr. Haak

## 12439 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R#1</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R#1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Aetna Road</b>		d. STREET ADDRESS <b>Mt. Aetna Road</b>	
3. NAME OF DECEASED (Type or print) First <b>FRANCES</b> Middle <b>MILDRED</b> Last <b>KENNEDY</b>		4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 16, 1869</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Sleepy Eye-Brown Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Francis M. Kennedy</b>		14. MOTHER'S MAIDEN NAME <b>Jerusha E. Post</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mrs. Mabel K. Moffett-Hagerstown R#1</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 1</b> , 19 <b>57</b> , to <b>Nov 21</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov 14</b> , 19 <b>57</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Paul Haak</b>		DATE SIGNED <b>22 Nov 57</b>	
PHYSICIAN'S NAME (Type) <b>PAUL HAAK, M.D.</b>		ADDRESS (Street, city or town, state) <b>28 W. Patomac</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-23-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Lutheran Ceme.</b>	22d. LOCATION (City, town, or county) (State) <b>Smithsburg-Wash. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman-Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR <b>120 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Chas. Lowrey</b>			

BUREAU V. 3

NOV 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12440 CERTIFICATE OF DEATH

12398

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Boonsboro</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u>			
c. LENGTH OF STAY IN 1b <u>weeks</u>				d. STREET ADDRESS <u>Fahrney Keedy Memorial Home</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fahrney Keedy Memorial Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Leslie</u> Last <u>Kepler</u>				4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/20/1871</u>	
9. AGE (In years last birthday) <u>86</u>		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min <u>11</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry M. Kepler</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Sanner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO <u>no</u>			
17. INFORMANT <u>Mrs. Annie Kepler, Middletown, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Renal-Vascular disease</u> <u>142X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Nov 11</u> , 19 <u>57</u> , that I lost saw the deceased alive on <u>Nov 2</u> , 19 <u>57</u> , and that death occurred at <u>7:05</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Middletown</u> DATE SIGNED <u>11-13-57</u> ACTUAL SIGNATURE <u>Elmer Harp</u> M.D. <u>Middletown</u> PHYSICIAN'S NAME (Type) <u>Dr. J. Elmer Harp</u> <u>Middletown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/14/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Nov. 14, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Best</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 15 1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12399

12392

## CERTIFICATE OF DEATH

Reg. Dist. No. 1302

## 1. PLACE OF DEATH

COUNTY Washington

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)  
HagerstownLENGTH OF STAY  
(In this place)  
2 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MdCOUNTY WashingtonCITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN RuralHOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS215 W. Washington St.STREET  
ADDRESSLeitersburg, Hagerstown R.D.53. NAME OF  
(Type or Print)

(First)

(Middle)

(Last)

DorisVirginiaKline4. DATE  
OF  
DEATH

(Month)

(Day)

(Year)

11/23/19 57

## 5. SEX

6. COLOR OR  
RACE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

## 8. DATE OF BIRTH

## 9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

femalewhiteMarried12/15/192135

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)House wife10b. KIND OF BUSINESS  
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Waynesboro, Pa.12. CITIZEN OF WHAT  
COUNTRY?U.S.A.

## 13. FATHER'S NAME

John E. Stover

## 14. MOTHER'S MAIDEN NAME

Clara M. Rowe15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS

Earl C. Kline, Hagerstown, R.D.5 Md.

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## 18. MEDICAL CERTIFICATION

INTERVAL BETWEEN  
ONSET AND DEATH4. IMMEDIATE CAUSE (A)  
ANTECEDENT CAUSE(S) DUE TO  
DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.  
(B)  
(C)Coronary Occlusion  
Arterio Sclerotic Heart10 months  
one year11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
While ☐ Not while ☐  
at work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-1-1957 to 11-23-1957, that I last saw the deceased  
alive on 11-10-1957 and that death occurred at 8:00 M., from the causes and on the date stated above.

SIGNATURE

Dr. E. W. Smith

M.D.

ADDRESS (Street, city, town, state)

Hagerstown Md

DATE SIGNED

11-23-5723. BURIAL, CREMATION,  
REMOVAL (SPECIFY)  
Burial

## DATE THEREOF

11/27/57

## NAME OF CEMETERY OR CREMATORY

Leitersburg, Lutheran

## LOCATION (City, town, or county)

Leitersburg, Md.

(State)

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

Nov. 26, 1957John H. Powers

## 25. FUNERAL DIRECTOR'S SIGNATURE

John H. PowersHagerstown R.D.5Waynesboro, Pa.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

BUREAU V. S.

NOV 10 1937

RECEIVED



12393

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Pennsylvania</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chambersburg, Pa.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1064 South Potomac Street</u>				d STREET ADDRESS <u>424 Elm Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>B.</u> Last <u>Knepper</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>1957</u>			
5 SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1876</u>	
9. AGE (In years last birthday) <u>81 yrs.</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>St. Thomas, Franklin Co. Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13 FATHER'S NAME <u>Abram Short</u>				14 MOTHER'S MAIDEN NAME <u>Sarah McCullough</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Charles W. Knepper, 416 Belvedere Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4 1.0 DUE TO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u></u> Year <u></u> Hour a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>11-10-1957</u> to <u>11-15-1957</u> , that I last saw the deceased alive on <u>11-15-1957</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>11/16/57</u>			
PHYSICIAN'S NAME (Type) <u>[Signature]</u>				M.D. <u>[Signature]</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-18-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Quincy, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				24a. REC'D BY REGISTRAR <u>11/18/57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 20 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cause of death MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12401

11-21-57

12394

Robert Webb, M.D. DME Webb Co.

# CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>934 Mulberry Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE POE LAMBERT</u>		4. DATE OF DEATH Month Day Year <u>Nov 18 1957 19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 27 1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Buyer Grocery Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George P. Lambert</u>		14. MOTHER'S MAIDEN NAME <u>Mary Shock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>214-09-7790</u>	
17. INFORMANT <u>Mrs Bertha K. Lambert</u>		Address <u>934 Mulberry Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Comp.</u> DUE TO (b) <u>Arteriosclerotic Cardio Vascular Dis.</u> DUE TO (c) <u>year</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/11/57</u> , 19 <u>57</u> , to <u>11/18/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/11/57</u> , 19 <u>57</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		M.D. <u>136 North Potomac St.,</u> DATE SIGNED <u>11/18/57</u>	
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/20/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt View Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Sharpsburg Wash. Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Nov 25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Weaver</u>	

RECEIVED

NOV 27 1957

BUREAU V. N.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12395

CERTIFICATE OF DEATH

12402

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Jackson Convalescent Home</b>		e. STREET ADDRESS <b>Williamsport</b>	
3. NAME OF DECEASED (Type or print) First <b>Nettie</b> Middle <b>Mae</b> Last <b>Landis</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>12,</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 26, 1888</b>
9. AGE (In years last birthday) yrs. <b>69</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>8</b> Days <b>17</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House duties</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Morgan Co. W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Newton Unger</b>		14. MOTHER'S MAIDEN NAME <b>Jenettia Jean Unger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Golden Landis</b>	
17. INFORMANT <b>Golden Landis</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>Yes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/31/57</b> , 19 <b></b> , to <b>9/25/57</b> , 19 <b></b> , that I last saw the deceased alive on <b>9/25/57</b> , 19 <b></b> , and that death occurred at <b>1:32 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Howard N. Weeks</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>136 North Potomac Street 11/13/57</b>	
PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/14/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Martinsburg W.Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. Brown</b>		24. REC'D BY REGISTRAR <b>NOV 18 1957</b>	
ADDRESS <b>Martinsburg W.Va.</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>	

BUREAU V. S.

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12396

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mercestown</u>		c. LENGTH OF STAY IN 1b <u>2 yrs. 7 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Barlock Conv. Home</u>		d. STREET ADDRESS <u>R.D.#1</u>	
3. NAME OF DECEASED (Type or print) First <u>LUCY</u> Middle <u></u> Last <u>LAUVER</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1, 1867</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Fulton Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jackson Mellott</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Harr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>**One</u>	
17. INFORMANT Address <u>Alvey Lauver, Ft. Loudon, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2.5 hr 10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/8</u> 19 <u>55</u> to <u>11/22</u> 19 <u>57</u> , that I last saw the deceased alive on <u>11/21</u> 19 <u>57</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>[Address]</u> DATE SIGNED <u>11/23/57</u>	
PHYSICIAN'S NAME (Type) <u>W. C. BREWER, M.D., GREENCASTLE, PENNA.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/21/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>	22d. LOCATION (City, town, or county) (State) <u>Conneellsburg, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Mercestown, Pa.</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

RECEIVED

NOV 27 1957

BUREAU V. B.



## 12397 CERTIFICATE OF DEATH

12404

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN TB <b>10 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>910 Main Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mollie</b> Middle <b>Rosadine</b> Last <b>Leasure</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>21</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 27 1882</b>	
9. AGE (In years last birthday) yrs. <b>75</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Ridgeville West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Jacob Liler</b>				14. MOTHER'S MAIDEN NAME <b>Serena Harding</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Runyan E Hartman</b>		Address <b>Little Rock Arkansas</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Collapse</b> DUE TO <b>Cerebral Vascular Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Atherosclerosis - Diabetes</b> DUE TO (c) <b>Atherosclerosis - Diabetes</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1955</b> , 19____, to <b>Nov 21, 1957</b> , that I last saw the deceased alive on <b>Nov 20, 1957</b> , and that death occurred at <b>2 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Louis E. Graft</b> M.D.				119 S. Hartman			
PHYSICIAN'S NAME (Type) <b>Louis E. GRAFT</b>				<b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/24/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Duling Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Keyser W. Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>				ADDRESS <b>Hagerstown Md</b>		24a. REC'D BY REGISTRAR <b>Nov. 26. 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>B. H. Powers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12398

## CERTIFICATE OF DEATH

Dr. Hirshman

12405

Reg. Dist. No. 502

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>45 Yrs</b>				d. STREET ADDRESS <b>327 N. Cannon Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>327 N. Cannon Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elsie</b> Middle <b>May</b> Last <b>Lehman</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>26</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>66 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Ganoe Town Berkeley City</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ephraim Kettering</b>				14. MOTHER'S MAIDEN NAME <b>Martha DeHaven</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Elsie Lucas, 327 N. Cannon Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>155X Carcinoma - Gall Bladder</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>							
DUE TO (b) <b>Hypertensive Cardiovascular Disease</b> <b>10 yrs -</b>							
DUE TO (c) <b>aortic Regurgitation</b> <b>10 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Feb. 1946</b> , to <b>Nov. 26, 1957</b> , that I last saw the deceased alive on <b>Nov. 11, 1957</b> , and that death occurred at <b>8 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>				DATE SIGNED <b>Nov. 29, 1957</b>			
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>				ADDRESS (Street, city or town, state) <b>159 W. Washington St., Hagerstown</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-30-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman, Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>Nov. 29, 1957</b>			
				24b. REGISTRAR'S SIGNATURE <b>Frank Bowers</b>			

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## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>47 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1138 Security Road</u>				e. STREET ADDRESS <u>1138 Security Road</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Alvey</u> Last <u>Lewis</u>				4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 17, 1867</u>		9. AGE (In years last birthday) yrs <u>90</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cement Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Near Downsville Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Betty Mull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-09-9890</u>		17. INFORMANT <u>Mrs. Elizabeth Lewis Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis, Generalized</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>				20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I attended the deceased from <u>16 Nov.</u> , 19 <u>57</u> , to <u>22 Nov.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>20 Nov.</u> , 19 <u>57</u> , and that death occurred at <u>3 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>135 N. Potomac St. Hager Md.</u> DATE SIGNED <u>Nov. 27, 1957</u>							
ACTUAL SIGNATURE <u>J. D. Wilson</u>				M.D. <u>135 N. Potomac St. Hager Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. D. Wilson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-25-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 27, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas H Powers</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 11 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV. 19 1957

BUREAU V.

RECEIVED

12441

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b>				c. LENGTH OF STAY IN 1b <b>17 MO.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>REEDER NURSING HOME</b>				e. STREET ADDRESS <b>NORTH MAIN STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>DENVER</b> Middle <b>GAINES</b> Last <b>LIGHTER</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>20</b> Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 17 1867</b>		9. AGE (In years last birthday) <b>90 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (State or foreign country) <b>NEAR KEEDYSVILLE WASH. CO. MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JOHN H. LIGHTER</b>				14. MOTHER'S MAIDEN NAME <b>SOPHIA SHIFLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT <b>DENVER G. WYAND BOONSBORO MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Tormented arterio-sclerosis</b> <b>X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of prostate</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 10, 1957</b> to <b>Nov. 20, 1957</b> , that I last saw the deceased alive on <b>Nov. 19, 1957</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore</b> DATE SIGNED <b>11/21/57</b>							
ACTUAL SIGNATURE <b>G. W. HeVan</b> M.D. <b>Baltimore</b>				DATE SIGNED <b>11/21/57</b>			
PHYSICIAN'S NAME (Type) <b>G. W. HeVan</b> Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. 23 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East End Home</b>				24a. REC'D BY REGISTRAR <b>John H. Badt</b>			
24b. REGISTRAR'S SIGNATURE <b>John H. Badt</b>				DATE <b>Nov 23, 1957</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12400 Item 3 File # 12-3-51 et  
**CERTIFICATE OF DEATH**

12408

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>3 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Homewood Church Home</b>				d. STREET ADDRESS <b>2034 Brookfield Ave. Homewood Church Home</b>			
3. NAME OF DECEASED (Type or print) First <b>SUSAN</b> Middle <b>ELIZA</b> Last <b>LITTLE</b>				4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 7, 1876</b>	
9. AGE (In years last birthday) <b>81 yrs.</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>17</b>		IF UNDER 24 HRS Hours <b></b> Min <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William E. Little</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Ellen Mc Cammon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Howard K. Stickall Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO <b></b> (c) <b></b> DUE TO <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hagerstown</b>				20g. (County) <b>Maryland</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>6-1-57</b> 19, to <b>11-24</b> 1957, that I last saw the deceased alive on <b>11-1-57</b> 19, and that death occurred at <b>Home</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b>				DATE SIGNED <b>11/25/57</b>			
ACTUAL SIGNATURE <b>A. E. Little</b>				M.D. <b>Hagerstown, Md.</b>			
PHYSICIAN'S NAME (Type) <b>A. E. Little</b>				DATE SIGNED <b>11/25/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/26/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Boyer</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Nov. 26, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>			

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## 12401 CERTIFICATE OF DEATH

Reg. Dist. No 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN lb <u>3 Hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sh. County Hospital</u>				/d STREET ADDRESS <u>Downsville- Wmspt Pike</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>REBA EXOMIA LONG</u>				4. DATE OF DEATH Month Day Year <u>November 7 1957 19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 13 1889</u>	9. AGE (In years last birthday) <u>67</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>St James Wash. Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Otho Slifer</u>				14. MOTHER'S MAIDEN NAME <u>Laura Fahrney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Brown C. Long Williamsport Md R #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>11/7/57</u> , 19 <u>57</u> , to <u>11/7/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/7/57</u> , 19 <u>57</u> , and that death occurred at <u>3</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph L. Young</u>		M.D. <u>Williamsport, Md</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>11/9/57</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Manor Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>near Tilghbranton Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Nov. 12, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Shasth Brown</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12410

12402

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elijah</b> Middle <b>Elwelton</b> Last <b>Loveless</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>11</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 7 1885</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>3</b> Hours <b></b> Min <b></b>		IF UNDER 24 HRS. Hours <b></b> Min <b></b>			
10a. USUAL OCCUPATION (Give kind of work done, dying most of working life, even if retired) <b>Labor Construction</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Jacob Loveless</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Swope</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>213-18-9204</b>		17. INFORMANT <b>Mrs. Addie Loveless</b> Address <b>1452 Jefferson St. Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>11/11/57</b> to <b>11/11/57</b> , that I last saw the deceased alive on <b>11/11/57</b> , and that death occurred at <b>4:45 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Robert L. Young</b> M.D. <b>William Augustus, Md 11/11/57</b>							
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Nov. 14-57</b>		<b>Bakersville Cemetery</b>		<b>Bakersville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Young</b>				ADDRESS <b>Willomgort, Md</b>		24a. REC'D BY REGISTRAR <b>Nov. 14, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Shast H. Bowers</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12403

## CERTIFICATE OF DEATH

12411  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington Co.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>3 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>804 Oak Hill Ave.</b>				d. STREET ADDRESS <b>804 Oak Hill Ave.</b>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BEULAH</b> Middle <b>ZEIGLER</b> Last <b>MARTIN</b>				4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>1957</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 22, 1888</b>			
9. AGE (In years last birthday) <b>69 yrs</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>13</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>F. Scott Zeigler</b>				14. MOTHER'S MAIDEN NAME <b>Kate Middlekauff</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-09-1621 A</b>		17. INFORMANT Name <b>Charles W. Martin</b> Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma (breast) left breast with</b> <b>170x</b> DUE TO <b>generalized metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO <b></b> (c) <b></b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month <b>19</b> Day <b></b> Year <b></b> Hour <b></b> a. m. <b></b> p. m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>			
20f. (City or town) <b></b>				20g. (County) <b></b>		20h. (State) <b></b>			
21. I certify that I attended the deceased from <b>Mar 1955</b> to <b>5 Apr 1957</b> , that I last saw the deceased alive on <b>5 Apr 1957</b> , and that death occurred at <b>8:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>230 N Potomac Hagerstown</b> DATE SIGNED <b>6 Apr 57</b> ACTUAL SIGNATURE <b>F. F. Lusby</b> M.D. <b></b> PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/8/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <b>D. Franklin Roper</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>11/20/57</b>			
				24b. REGISTRAR'S SIGNATURE <b>Chas H Bowers</b>					

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12412	
Item 18 Film 2-3											
12404 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 302	
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>					d. STREET ADDRESS <b>326 Buena Vista Ave.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>THERESA COLLEEN MC CAPREN</b>			First Middle Last			4. DATE OF DEATH <b>November 11 1957</b>		Month Day Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 7, 1947</b>		9. AGE (In years last birthday) <b>9 yrs.</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>4</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Louis E. Mc Carren</b>					14. MOTHER'S MAIDEN NAME <b>Evelyn College</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Louis Mc Carren Hagerstown, Md.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute military tuberculosis</b> <b>010X</b> DUE TO <b>Undetermined x pending autopsy reports.</b> Conditions, if any, which gave rise to immediate cause (b) <b>Acute tubercular encephalitis</b> (c) <b>Acute tubercular encephalitis</b> (c) <b>Acute tubercular encephalitis</b> DUE TO <b>Acute tubercular encephalitis</b> cause lost.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE <b>S. Robert Wells</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			11-12-57			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/14/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <b>R. Franklin Rouzer</b>						ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>20018.1957</b>		24b. REGISTRAR'S SIGNATURE <b>Shall H. J. J. J.</b>	

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NOV 20 1957

BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Layman

12405

CERTIFICATE OF DEATH

Reg. Dist. No.

12413  
302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN ID <u>4 Mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT LEE MILLESON</u>		4. DATE OF DEATH Month Day Year <u>November 23 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10 1881</u>
9. AGE (In years last birthday) yrs. <u>76</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector P. R. R. Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va. Co. Springfield Hampshire</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Milleson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Milleson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <u>No</u>		16. SOCIAL SECURITY NO <u>716-09-6693</u>	
17. INFORMANT <u>Mrs. Ernest McKee</u>		Address <u>236 Rosemont Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO 4-10-0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>2 years (certain)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease (2 years-certain)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 17</u> , 19 <u>57</u> , to <u>November 23</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 22</u> , 19 <u>57</u> , and that death occurred at <u>7:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Dr. W. T. Layman</u> M.D. <u>100 Professional Arts. Bldg. 11/23/57</u> PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u> <u>Hagerstown,</u> <u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 26 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Hebron Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Winchester Frederick Co Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Nov 26, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Bowers</u>	

BUREAU V. S.

NOV 29 1957

RECEIVED

12406

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		d. STREET ADDRESS 1106 Oak Hill Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle R Last Millhouse		4. DATE OF DEATH Month 11 Day 13 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1895
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR INDUSTRY Hoffman Cloth. Store Penna.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel C. Millhouse		14. MOTHER'S MAIDEN NAME Margaret Morehead	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) yes W.W. I		16. SOCIAL SECURITY NO	
17. INFORMANT William M. Millhouse		Address Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 480x PNEUMONIA DUE TO Influenza Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 wk 15 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 27, 1957, to Nov. 13, 1957, that I last saw the deceased alive on Nov. 13, 1957, and that death occurred at 8 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip J. Hirshman M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 159 W. Washington St. Hagerstown Md. 11/15/57	
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D. 159 W. Washington St. Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 11-15-57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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NOV 19 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, if he is the attending physician, must completely fill in the funeral director's section. The funeral director, if he is the attending physician, must completely fill in the funeral director's section. The funeral director, if he is the attending physician, must completely fill in the funeral director's section.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12415

## 12407 CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>36 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2007 Virginia Ave</u>				d. STREET ADDRESS <u>3007 Virginia Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLETCHER EMERSON MITCHELL</u>				4. DATE OF DEATH Month Day Year <u>Nov 28 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28 1885</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Station Supervisor Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Mitchell</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Gallahan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-1611</u>		17. INFORMANT Address <u>Mrs Ada C. Mitchell 2007 Virginia Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> <u>yes.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	Month <u>11</u>	Day <u>30</u>	Year <u>1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hagerstown Md.</u>	20f. (City or town) <u>Hagerstown</u>	(County) <u>Washington</u>
21. I certify that I attended the deceased from <u>Nov 28</u> , 19 <u>57</u> , to <u>Nov 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 28</u> , 19 <u>57</u> , and that death occurred at <u>3:55 AM</u> , from the causes and on the date stated above.						DATE SIGNED <u>11-29-57</u>	
ACTUAL SIGNATURE <u>Louis S. Graff</u>				M.D. <u>119 C Antietam</u>			
PHYSICIAN'S NAME (Type) <u>Louis S. GRAFF M.D.</u>				<u>Hagerstown Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/30/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Hagerstown</u>		(State) <u>Washington Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Dec 3 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Wash. Bowers</u>

BUREAU V. A.

1957

157



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers and return them to the funeral director. A signature prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12408

CERTIFICATE OF DEATH

Dr. E. W. Ditto, 111

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>1 week</b>				d. STREET ADDRESS <b>625 Jefferson St.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Greg</b> Last <b>Mower</b>				4. DATE OF DEATH Month <b>1</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Franklin Cty., Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Mower</b>				14. MOTHER'S MAIDEN NAME <b>Lousanna Willis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service) <b>---</b>				16. SOCIAL SECURITY NO <b>---</b>			
17. INFORMANT <b>Mrs Paul McNamee</b> Address <b>229 Norway Ave.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>300X</b> <b>General arteriosclerosis with</b> DUE TO <b>cerebral thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> DUE TO <b>---</b> (c) <b>---</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostate hypertrophy, benign</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <b>19</b> Day <b>1</b> Year <b>1954</b> Hour <b>a. m</b> p. m <b>---</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 1, 1954</b> , to <b>May 7, 1957</b> , that I last saw the deceased alive on <b>May 2, 1957</b> , and that death occurred at <b>6:00 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edward W. Ditto</b>				ADDRESS (Street, city or town, state) <b>MD. 217 W. Washington Street</b>			
DATE SIGNED <b>11/8/57</b>							
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto 111, 1 D. Hagerstown, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 11, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Broadfording Cem.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman, Hagerstown, Md.</b>				24b. REC'D BY REGISTRAR <b>Nov 12, 1957</b>			
				24c. REGISTRAR'S SIGNATURE <b>Shaff Powers</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12417

## 12409 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>3 mos. 4 das.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <u>Maple Ave</u>							
3. NAME OF DECEASED (Type or print) First <u>SUDIE</u> Middle <u>IRENE</u> Last <u>NEWMAN</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>21</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 14 1880</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cavetown Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George A Pound</u>				14. MOTHER'S MAIDEN NAME <u>Sally E Oswald</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>Hoy D Newman</u> Address <u>Smithsburg Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary Thromboses</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u> <u>3 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>19</u> p. m. <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>2-6-</u> 19 <u>57</u> , to <u>11-21-</u> 19 <u>57</u> , that I last saw the deceased alive on <u>11-21-</u> 19 <u>57</u> , and that death occurred at <u>4:25 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Smithsburg, Maryland</u> DATE SIGNED <u>  </u>							
ACTUAL SIGNATURE <u>Charles E. Hess</u> M. D.							
PHYSICIAN'S NAME (Type) <u>Charles F. Hess, MD</u>				<u>11/23/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> ADDRESS <u>Hagerstown Md</u>				24a. REC'D BY REGISTRAR <u>Nov. 26. 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. H. Powers</u>	

BUREAU

NOV 23 1967

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12442

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12418

Dr. Wells

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 316

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keedysville, Md.</u>		c. LENGTH OF STAY IN 1b <u>24 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dog St. Road</u>				d. STREET ADDRESS <u>Broadfording Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WILLIAM</u> Last <u>PALMER</u>				4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 5, 1878</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Liller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Md. Cearfoss-Wash. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>No Record</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  -  -  -</u>		17. INFORMANT <u>Wm. H. McNamee-R#6-Hagerstown, Md.</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month, Day, Year <u>none 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u>  </u>		(County) <u>  </u>	(State) <u>  </u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u> EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>Nov. 26 '57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown-Wash. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Maryland</u>				24. REG. BY REGISTRAR <u>NOV 29 1957</u> REGISTRAR'S SIGNATURE <u>Russell Keating</u>			

RECEIVED  
NOV 29 1957  
BUREAU V. S.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12443**  
**CERTIFICATE OF DEATH**

12419  
202

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Nursing Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Smithsburg, Md.</b>			
				d. STREET ADDRESS <b>R.D.# 2</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Edward</b> Last <b>Poddicord</b>				4. DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 13, 1876</b>	
				9. AGE (In years last birthday) yrs <b>81</b>		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Thurmont, Maryland</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Poddicord</b>				14. MOTHER'S MAIDEN NAME <b>Helen Butt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>George W. Poddicord</b> Address <b>Emmitsburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate</b> DUE TO <b>Arterial Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b> <b>10 yrs.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct 15, 1957</b> to <b>Nov 3, 1957</b> , that I last saw the deceased alive on <b>Nov 2, 1957</b> , and that death occurred at <b>4:50 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David R. Brewer</b> M.D.				ADDRESS (Street, city or town, state) <b>Clear Spring</b> DATE SIGNED <b>11/3/57</b>			
PHYSICIAN'S NAME (Type) <b>David R. Brewer</b> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/6/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Anthony's Shrine</b>		22d. LOCATION (City, town, or county) (State) <b>Emmitsburg, R.D.1, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. L. Allison</b>				ADDRESS <b>Emmitsburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>11/10/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas. Brewer</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. 1 and 2 should be filed with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 12 1957

BUREAU V. S.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. JUDICIAL PRIOR TO BURIAL, CREMATION, REMOVAL.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12420

12444

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ernstville</b> c. LENGTH OF STAY IN 1b <b>2½ hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>In Field while Hunting</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>18 Avalon Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>CLARENCE</b> Last <b>PRESGRAVES</b>				4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 23, 1882</b>	
9. AGE (In years last birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>6</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Western Md. R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Vaughn Summit, Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Joseph Thomas Presgraves</b>				14. MOTHER'S MAIDEN NAME <b>Margaret M. Vaughn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>705-10-7620</b>		17. INFORMANT Address <b>Mrs. Margaret C. Presgraves Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1 Acute Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b></b> (c), stating the underlying cause lost. DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) <b>-</b> (County) <b>-</b> (State) <b>-</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/2/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Suter-Rouzer Funeral Home Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>Dec 3 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Robert H. Powers</b>	

BOARD V. S.

DEAL

## 12410 CERTIFICATE OF DEATH

Reg. Dist. No.

1302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write full name and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
f. STREET ADDRESS <b>335 S. LOCUST ST.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NETTIE</b> First <b>MAY</b> Middle <b>RUDISILL</b> Last		4. DATE OF DEATH <b>NOV.</b> Month <b>1</b> Day <b>19</b> Year <b>57</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/20/1872</b>
9. AGE (In years lost birthday) <b>85</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM H. THOMAS</b>		14. MOTHER'S MAIDEN NAME <b>MATY ANNA McDADE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>MRS. PEARL STORMS</b>		18. ADDRESS (Street, city or town, state) <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b> DUE TO (b) <b>with general arteriosclerosis</b> DUE TO (c) <b>&amp; cerebral thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>9 Interosteoblastic fracture right hip</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 1</b> , 1954, to <b>Nov 1</b> , 1957, that I last saw the deceased alive on <b>Nov 1</b> , 1957, and that death occurred at <b>2 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Edward W. Ditto III M.D.</b>			
22. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M.D. 217 W. Washington St. Hagerstown, Md.</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/4/47</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Perment, Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>Nov 4 1957</b> 24b. REGISTRAR'S SIGNATURE <b>John H. Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 6 1957

RECEIVED

## 12411 CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b _____			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				e. STREET ADDRESS <u>SMITHSBURG MD. Box 131</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SUSAN — MAY — RUTHS</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER — 28 — 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 27. 1957</u>	9. AGE (In years last birthday) yrs <u>ONE</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HAGERSTOWN MD</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		
13. FATHER'S NAME <u>HOWARD RUTHS JR.</u>				14. MOTHER'S MAIDEN NAME <u>LORETTA WINDERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>HOWARD RUTHS JR. SMITHSBURG MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (5 1/2 mo Pregnancy)</u> DUE TO <u>116 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>27 Nov 1957</u> to <u>28 Nov 1957</u> that I last saw the deceased alive on <u>27 Nov 1957</u> and that death occurred at <u>4 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>J. D. Wilson</u> M.D.							
PHYSICIAN'S NAME (Type) <u>J. D. Wilson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>NOV. 30. 1957</u>		<u>SMITHSBURG CEMETERY</u>		<u>SMITHSBURG MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PAST FUNERAL HOME BOONSBORO</u>				24a. REC'D BY REGISTRAR <u>Nov 2, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Shirley H. Hovvers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 3 Film G222 11-8-57 et  
12412  
CERTIFICATE OF DEATH

12423

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 1/2 Hrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 921 Kenwood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sylvia First Lee Middle Salvatore Last <del>Priscilla Baby Girl of Harry Salvatore</del>		4. DATE OF DEATH Month November Day 4 Year 1957		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 4 1957	
9. AGE (In years last birthday) yrs. 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Md. Hagerstown Wash. Con		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Harry L. Salvatore				14. MOTHER'S MAIDEN NAME Mary E. Fltecher							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Harry L. Salvatore		Address 921 Kenwood Drive					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atelctosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Immaturity</i> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/4, 1957, to 11/4, 1957, that I last saw the deceased alive on 11/4, 1957, and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED F. D. Dove November 4, 1957 214 N. Potomac St., Hagerstown, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman						ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Nov. 6/1957		24b. REGISTRAR'S SIGNATURE R. H. Powers	

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12413

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>18 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>36 So Cannon Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE FLORENCE SCHILDKNECHT</u>				4. DATE OF DEATH Month Day Year <u>Nov 14 1957 19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 31 1882</u>	
9. AGE (In years last birthday) yrs. <u>75</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Theodore Schildknecht</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Houpt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Pauline Fields 422 No Locust St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> Hagerstown Md. INTERVAL BETWEEN ONSET AND DEATH <u>Short interval</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> Indefinite DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug. 12, 1949</u> to <u>Nov. 14, 1957</u> , that I last saw the deceased alive on <u>Sept. 24, 1957</u> , and that death occurred at <u>Exact time not known</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. B. Kneisley</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>148 West Washington St. 11/18/57</u>			
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>				<u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 20, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Blair H. Sowers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be filled in by the funeral director, and the certificate should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

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## CERTIFICATE OF DEATH

Reg. Dist. No. 302

12414

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>10 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X/ MONROE RURAL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>BOONSBORO MD. ROUTE 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALVEY</b> Middle <b>D.</b> Last <b>SCHLOSSER</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEBRUARY 9 1883</b>	
9. AGE (In years last birthday) <b>74 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (State or foreign country) <b>MONROE WASH. CO. MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOSIAH SCHLOSSER</b>		14. MOTHER'S MAIDEN NAME <b>SAVILLA DOUB</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215 36 6812</b>		17. INFORMANT <b>HARVEY J. SCHLOSSER BOONSBORO MD. R 1.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia - broncho.</b> <b>480X</b> DUE TO Influenza Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <b>13 days</b> <b>13 days</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardio-vascular-renal disease</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>50</b>	
20f. (City or town) <b>Sharpsburg, Md.</b>				20g. (County) <b>Washington</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Oct. 26</b> , 19 <b>50</b> , to <b>11/7/57</b> , that I last saw the deceased alive on <b>Nov. 10 6</b> , 19 <b>57</b> , and that death occurred at <b>3 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sharpsburg, Md.</b> DATE SIGNED <b>11/8/57</b> ACTUAL SIGNATURE <b>Walter H. Shealy</b> M.D. PHYSICIAN'S NAME (Type) <b>Walter H. Shealy M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. 10 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Funeral Home Boonsboro Md.</b>				24. REC'D BY REGISTRAR <b>Nov 13 1957</b>		24b. REGISTRAR'S SIGNATURE <b>East H. Boonsboro</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. DEPT. OF JUSTICE

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12445 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Rt # 5</b>		c. LENGTH OF STAY IN 1b <b>39 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Leitersburg Pike</b>		d. STREET ADDRESS <b>Leitersburg Pike Hagerstown Rt/5</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BENJAMIN HARRISON SHANK</b>		4. DATE OF DEATH Month Day Year <b>November 23 19 57</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan'y 9 1891</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dairy Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>	
11 BIRTHPLACE (State or foreign country) <b>Id</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Calvin S. Shank</b>		14. MOTHER'S MAIDEN NAME <b>Ida C. Spessard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mrs Anna Shank Hagerstown Id. Rt # 5</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Hypertensive Cerebro Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>---</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yr</b> <b>5 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-1-</b> , 19 <b>56</b> , to <b>11-23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11-24-57</b> , 19 <b>57</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. P. D. [Signature]</b>		M.D. <b>Hagerstown Md</b> <b>11/26/57</b>	
PHYSICIAN'S NAME (Type) <b>S. P. D. [Signature]</b>		<b>Hagerstown Md</b> <b>11/25/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/26/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town or county) (State) <b>Hagerstown Wash. Co Id</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman-Hagerstown, Maryland</b>		24a REC'D BY REGISTRAR <b>Nov 29 1957</b> 24b REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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BUREAU V. S.

## CERTIFICATE OF DEATH

12427

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>		c. LENGTH OF STAY IN 1b <u>3 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Catherine</u> Last <u>Shoemaker</u>		4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12.4.1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Fink</u>		14. MOTHER'S MAIDEN NAME <u>Annie McCormick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Cleveland T Shoemaker</u>		Address <u>Hancock Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Indeterminate</u> <u>unknown</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 26</u> , 19 <u>57</u> , to <u>Nov. 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 28</u> , 19 <u>57</u> , and that death occurred at <u>5:45 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>100 Professional Arts Bldg. 11/30/57</u>			
ACTUAL SIGNATURE <u>William T. Layman</u>		M.D. <u>100 Professional Arts Bldg. 11/30/57</u>	
PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>		<u>Hagerstown</u> <u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12.2.57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stone Bridge Brethern</u>	22d. LOCATION (City, town, or county) (State) <u>Near Hancock Washington Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard L. Stone</u>		ADDRESS <u>Hancock Md.</u>	
24a. REC'D BY REGISTRAR <u>Dec 3. 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

БЮЛЕТЕНЬ В. 2

1987 г.  
№ 1



## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>24 E. Water St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DAISY</u> Middle <u>MAUDE</u> Last <u>SOUTH</u>		4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>19 57</u>	
5 SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 7, 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11 BIRTHPLACE (State or foreign country) <u>Washington Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Slick</u>		14. MOTHER'S MAIDEN NAME <u>Anna Masters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Mrs. Geo. K. Poffenberger</u>		Address <u>Rt. #4 Waynesboro, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 Min.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19 57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I attended the deceased from <u>11/6</u> , 19 <u>57</u> , to <u>11/22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/22</u> , 19 <u>57</u> , and that death occurred at <u>11:05 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Smithsburg, Md.</u> DATE SIGNED <u>11/22/57</u>			
ACTUAL SIGNATURE <u>Charles F. Hess</u>		M.D. <u>Smithsburg, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u>		<u>Smithsburg Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 24, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg</u>	22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Wash. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul F. Bittle</u>		ADDRESS <u>Myersville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 25 '57</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

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12416

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		e. STREET ADDRESS 147 High St.,	
3. NAME OF DECEASED (Type or print) First Meda Middle A Last Spielman		4. DATE OF DEATH Month 11 Day 14 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1884
9. AGE (In years last birthday) 73 yr.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home duties		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Storm		14. MOTHER'S MAIDEN NAME Susan Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-30-7630	
17. INFORMANT Mrs. Edna M. Davies		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary thrombosis</i> (c) <i>Myocardial infarction</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-4-1927 to 11-14-1927, that I last saw the deceased alive on 11-12-1927, and that death occurred at 3:45 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Fred W. Kraiss</i>		DATE SIGNED 11/14/27	
PHYSICIAN'S NAME (Type) <i>Fred W. Kraiss</i>		M.D. <i>Charles H. Bowers</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-16-57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR 11/18/57		24b. REGISTRAR'S SIGNATURE <i>Charles H. Bowers</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, this 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

3 should be detached for use as the burial-transit permit, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers as 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12417

## CERTIFICATE OF DEATH

Dr. Cohn  
12430  
Reg. Dist. No. 303

1 PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>4 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>nr. Wilsons-Hagerstown R#2</b>		d. STREET ADDRESS <b>Wash. Co. Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Martin Manor Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>M.</b> Last <b>SPRECHER</b>		4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26, 1878</b>
9. AGE (In years last birthday) <b>79</b> yrs		IF UNDER 1 YEAR: Months <b>11</b> Days <b>21</b> Hours <b>57</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter H. Breitweiser</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth A. Bachtell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	
17. INFORMANT <b>Lloyd Sprecher-New York City</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE WITH HEMIPLEGIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>HYPERTENSIVE HEART DISEASE</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>ONE WEEK</b> <b>15 YEARS</b>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY 13</b> , 19 <b>44</b> , to <b>NOV 21</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>NOV 18</b> , 19 <b>57</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Archib Robert Cohen</i> M.D.			
PHYSICIAN'S NAME (Type) <b>ARCHIE ROBERT COHEN, M.D. CLEAR SPRING, MARYLAND 11/22/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-24-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman-Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR <b>Nov 26 1957</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Chas. Powers</i>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12418 CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waverstown</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural--Waverstown, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hosp.</u>				d. STREET ADDRESS <u>R.D.#2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>C</u> Last <u>Stenger</u>				4. DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1, 1886</u>	9. AGE (In years lost birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Part attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Amusement park</u>		11. BIRTHPLACE (State or foreign country) <u>Mercersburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William I. Stenger</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Lummert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>183-18-0971</u>		17. INFORMANT <u>Thos. L. Stenger, Waverstown, Md. R.D.#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary emphysema</u> <u>502.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic bronchitis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive heart disease</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 15</u> , 19 <u>57</u> , to <u>Nov. 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 13</u> , 19 <u>57</u> , and that death occurred at <u>3:20 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Clear Spring, Maryland</u> DATE SIGNED <u>11/15/57</u>							
ACTUAL SIGNATURE <u>Archie Robert Cohen</u>		M.D. <u>  </u>					
PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u>		<u>Clear Spring, Maryland 11/15/57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		22d. LOCATION (City, town, or county) (State) <u>Mercersburg, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.M. Lamminger</u>				ADDRESS <u>Mercersburg, Pa.</u>		24a. REC'D BY REGISTRAR <u>Nov. 19, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Gowers</u>			

BUREAU V. S.

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## 12447 CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>3½ years</u>		d. STREET ADDRESS <u>560 Jefferson St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Effie</u> Middle <u>Bell</u> Last <u>Stine</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 28, 1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Cyrus Barnhart</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Sites</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs. Lulu Stottlemeyer Rt. 3 Hag. d.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Sclerosis</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterial Sclerosis</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar. 17, 1954</u> to <u>Nov. 24, 1957</u> that I last saw the deceased alive on <u>Nov. 23, 1957</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Clearspring Md.</u> DATE SIGNED <u>David R. Brewer</u>			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D. <u>Clearspring Md.</u>			
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-26-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Reform Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>St. Line Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 27, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

124:9

CERTIFICATE OF DEATH

12433

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leesburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leesburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Orpha</u> Middle <u>Elizabeth</u> Last <u>Stouffer</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>6,</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 6, 1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>  </u>							
13. FATHER'S NAME <u>John W. Harsh</u>				14. MOTHER'S MAIDEN NAME <u>Malinda Marotte</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mrs. Nancy Newcomer, Leesburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/5/57</u> to <u>11/6/57</u> , that I last saw the deceased alive on <u>11/5/57</u> , 19 <u>  </u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Leesburg, Md.</u> DATE SIGNED <u>11/7/57</u> ACTUAL SIGNATURE <u>Ralph F. Young M.D.</u> PHYSICIAN'S NAME (Type) <u>Ralph F. Young</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11-8-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>near Leesburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son, Leesburg, Md.</u>				24a. REC'D BY REGISTRAR <u>Nov 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>	

BUREAU V. S.

NOV 15 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12420 CERTIFICATE OF DEATH

12434

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>2 hrs.</b>				d. STREET ADDRESS <b>212 Fairground Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>OLIVE CORA STRICKLAND</b>				4. DATE OF DEATH Month Day Year <b>November 3 1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 28, 1889</b>	
9. AGE (In years last birthday) <b>68 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min <b>2 5</b>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Girdletree, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John W. Jones</b>				14. MOTHER'S MAIDEN NAME <b>Cora Robinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT Address <b>Mr. Alfred E. Strickland Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b>							
b. <b>Undetermined cause</b>							
c. <b>Diabetes mellitus (duration 30 years) with acidosis &amp; precoma (da. history)</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus (duration 30 years) with acidosis &amp; precoma (da. history)</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Nov. 3, 1957</b> to <b>Nov. 3, 1957</b> , that I last saw the deceased alive on <b>Nov. 3, 1957</b> , and that death occurred at <b>4:45 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. T. Layman</b>				DATE SIGNED <b>Hagerstown, Md.</b>			
PHYSICIAN'S NAME (Type) <b>W. T. Layman, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/6/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Girdletree Methodist Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Girdletree, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>				ADDRESS <b>Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>Nov 6 1957</b>	
25. REGISTRAR'S SIGNATURE <b>Shatt. Bowers</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 1957

RECEIVED

## 12421 CERTIFICATE OF DEATH

Dr. Binford

Reg. Dist. No. 302

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and in any event within 72 hours after death, register prior to burial, cremation, or removal.

1 PLACE OF DEATH o COUNTY <u>Washington</u> o STATE <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Hagerstown</u>	
		d. STREET ADDRESS <u>R # 6</u>	
3 NAME OF DECEASED (Type or print) First <u>Amy</u> Middle <u>Elizabeth</u> Last <u>Strite</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 8, 1904</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Betre</u>		14. MOTHER'S MAIDEN NAME <u>Mary Byers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Chester Strite, Hagerstown, R#6, Md.</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of lungs</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adenocarcinoma of breast - metastases</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>2+ yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>21 Sept., 1957</u> to <u>8 Nov.</u> , 1957, that I last saw the deceased alive on <u>8 Nov.</u> , 1957, and that death occurred at <u>9 A. M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED <u>8 Nov 57</u>	
ACTUAL SIGNATURE <u>Richard T. Binford</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD, M.D.</u>		<u>1135 POTOMAC AVENUE; HAGERSTOWN, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-11-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>1008.12.1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Shasth Bowers</u>	

BUREAU V. S.

NOV 17 1964

RECEIVED



## CERTIFICATE OF DEATH

Reg. Dist. No.

302

12422

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institutional Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 2 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 116 WAYSIDE AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) MYRTLE IRENE TALBERT		4. DATE OF DEATH NOV. 17 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/25/1883
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK THOMAS BARR		14. MOTHER'S MAIDEN NAME MARGARET C. MALOTT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MRS. MARGRET SNYDER		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive - Cardiovascular D. (c) Arterio-sclerosis generalized			INTERVAL BETWEEN ONSET AND DEATH 10 1/2 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 22, 1956, to Nov. 17, 1957, that I last saw the deceased alive on Nov. 17, 1957, and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Sidney Novenstein M.D.		ADDRESS (Street, city or town, state) Hagerstown Md. DATE SIGNED 11-18-57	
PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/19/57	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. T. Hornum		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE Nov. 20, 1957		24b. REGISTRAR'S SIGNATURE Robert K. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

NOV 2 1957

RECEIVED

## 12423 CERTIFICATE OF DEATH

Reg. Dist. No.

12437  
302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b> d. STREET ADDRESS <b>R.F.D. # 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CLARENCE</b> First <b>VICTOR</b> Middle <b>TRUMPOWER</b> Last		4. DATE OF DEATH <b>November</b> Month <b>10</b> Day <b>19</b> Year <b>57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 9, 1887</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR <b>1</b> Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Wood Machine Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Organ Manufacture</b>	
11. BIRTHPLACE (State or foreign country) <b>Near Clear Spring, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nelson Trumpower</b>		14. MOTHER'S MAIDEN NAME <b>Lucinda Repp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>214-09-7004</b>	
17. INFORMANT <b>Mrs. Robert Bowman</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>451x Ruptured Abdominal Aneurysm</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>suddenly</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 10</b> , 19 <b>57</b> , to <b>Nov. 12</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov 10</b> , 19 <b>57</b> , and that death occurred at <b>3 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>136 North Potomac St.</b> DATE SIGNED <b>11/12/57</b>			
ACTUAL SIGNATURE <b>Howard N. Weeks</b> M.D.		DATE SIGNED <b>11/12/57</b>	
PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		<b>Hagerstown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/13/1957</b>	22c. NAME OF CEMETERY OR CREMATORIARY <b>St. Paul's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>St. Paul's, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Rouzer</b>		24a. REC'D BY REGISTRAR <b>Nov 13 1957</b>	
ADDRESS <b>Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Shirley G. Howard</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return them to the funeral director. The funeral director should register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 17 1964

RECEIVED

12448

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hancock Rest Home</u>		d. STREET ADDRESS <u>502 Oldtown Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mamie</u> Middle <u>Peebles</u> Last <u>Weber</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 22, 1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>19</u> Hours <u>30</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Peebles</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fleming</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Louis Young</u>		Address <u>Cumberland, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 30, 1957</u> to <u>Nov 14, 1957</u> that I last saw the deceased alive on <u>Nov 8, 1957</u> and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>H. E. Tabler</u> M.D. <u>Hancock, Maryland</u>		PHYSICIAN'S NAME (Type) <u>H. E. Tabler</u> <u>Hancock, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dak Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Lonaconing, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u>		ADDRESS <u>Cumberland, Md</u>	
24a. REC'D BY REGISTRAR <u>11/12/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. A. Heller, Jr.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 15 1927

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12424 CERTIFICATE OF DEATH

Reg. Dist. No.

12439  
302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>153 S. Mulberry St</u>				d. STREET ADDRESS <u>153 S. Mulberry St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Fenton Wenner</u>				4. DATE OF DEATH Month Day Year <u>November 7 19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 10, 1890</u>	
9. AGE (In years last birthday) <u>67</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Yardmaster</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Brunswick Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u></u>							
13. FATHER'S NAME <u>Charles M. Wenner</u>				14. MOTHER'S MAIDEN NAME <u>Edna Garrott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u>705-05-7883</u>			
17. INFORMANT <u>Miss E. Virginia Wenner</u>				Address <u>Brunswick Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u>							
(c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/25/57</u> , 19 <u>57</u> , to <u>11/7/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/10/57</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard N. Weeks</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>136 N. Potomac St. Hag. Md.</u> <u>11/9/57</u>			
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marks Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Petersville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son</u>				ADDRESS <u>Hagerstown Md.</u>			
24a. REC'D BY REGISTRAR <u>12/19/57</u>				24b. REGISTRAR'S SIGNATURE <u>John H. Packer</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.  
3 should be detached for use as the burial-transit permit. Then please remove carbon papers.  
1 and 2 should be filed with Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 15 1904

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12449 CERTIFICATE OF DEATH

124490

Reg. Dist. No. 144

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Jefferson</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harper's Ferry, W. Va.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Convalescent Home, Hagerstown Md.</u>		d. STREET ADDRESS <u>Fillmore St.</u>	
3. NAME OF DECEASED (Type or print) <u>Anna</u> First <u>Murphy</u> Middle <u>Whitmore</u> Last		4. DATE OF DEATH Month <u>Nov.</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>James N. Murphy</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Jefferson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Nellie K. Murphy, 3122 Perryville Ave, Pittsburgh, Pa.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic Heart Disease</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Jan 1954</u> to <u>Nov. 7, 1957</u> that I last saw the deceased alive at <u>Nov. 7, 1957</u> , and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>		DATE SIGNED <u>11/14/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 10, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Harper</u>	22d. LOCATION (City, town, or county) (State) <u>Harper's Ferry W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rose S. Dailey</u>		ADDRESS <u>Harper's Ferry, W. Va.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Charles R. Brewer</u>	
DATE <u>11-16-57</u>			

MEDICAL CERTIFICATION

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, as 1 and 2 should be filed with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 19 1957

RECEIVED

## 12425 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1 PLACE OF DEATH a. COUNTY Washington MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN TB 11 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Smithsburg Box 124	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION sh. County Hospital				d STREET ADDRESS Henrietta St		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last MARGARET ALMETA WILLIAMS				4 DATE OF DEATH Month Day Year November 17 1957			
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 11 1892		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11 BIRTHPLACE (State or foreign country) Pa. Waynesboro Franklin Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Conrad				14. MOTHER'S MAIDEN NAME Elvie Baker			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service) None		17 INFORMANT Address D. Ralph Williams Smithsburg Box 124			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease 2 yrs. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 Days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 11/5, 1957, to 11/17, 1957, that I last saw the deceased alive on 11/16, 1957, and that death occurred at 2:5 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Charles G. Hines M.D. Smithsburg, Md. 11/18/57 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/20/57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR DATE 11/20/57		24b. REGISTRAR'S SIGNATURE Charles Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU N. B.

NOV 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12442

12426

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>216 N. Locust St.</u>				d. STREET ADDRESS <u>216 N. Locust St.</u>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>D.</u> Last <u>WOLFE</u>				4. DATE OF DEATH Month <u>11</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/12/1879</u>	
9. AGE (In years last birthday) yrs. <u>78</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miller</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Flour Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Funkstown, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Daniel Wolfe</u>				14. MOTHER'S MAIDEN NAME <u>Susan Bowman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-09-4911</u>		17. INFORMANT <u>Mrs. J.E. Pleasant</u> Address <u>R #4 Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>2 yr.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>2-5-</u> , 19 <u>57</u> , to <u>11-22-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-22-</u> , 19 <u>57</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D.				ADDRESS (Street, city or town, state) <u>Smithsburg, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M.D.</u>				VANDYKE <u>4-4061</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Funkstown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Funkstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc.</u>				ADDRESS <u>1601 Penna. Ave. Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 25, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>			

Wm. G. Frank Urban

BUREAU V. S.

NOV 27 1957

RECEIVED

11/27/57

12450

## CERTIFICATE OF DEATH

12443

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b>				c. LENGTH OF STAY IN 1b <b>50 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>241 NORTH MAIN STREET</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b>			
				d. STREET ADDRESS <b>241 NORTH MAIN STREET</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LUCY</b> Middle <b>E</b> Last <b>YOUNG</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>8</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 11 1875</b>	
9. AGE (In years last birthday) <b>82</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>NEAR MIDDLETOWN FRED.CO.MD. U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>FRANCIS ALEXANDER</b>				14. MOTHER'S MAIDEN NAME <b>LYDIA E. SMITH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. MARGARET STERNER BOONSBORO MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> DUE TO <b>Cerebral Haemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Haemorrhage</b> (c) <b>12 yrs</b> <b>1 day</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs</b> <b>1 day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>August 10, 1954</b> , to <b>Nov 8</b> , 1957, that I last saw the deceased alive on <b>Nov 8</b> , 1957, and that death occurred at <b>5 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. W. LeVan</b> M.D.				ADDRESS (Street, city or town, state) <b>Boonsboro</b> DATE SIGNED <b>11/9/57</b>			
WITNESS NAME (Type) <b>G. W. LeVan</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. 11 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town or county) (State) <b>BOONSBORO WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul Foul House Boonsboro Md</b>				24a. REC'D BY REGISTRAR <b>DATE 11-11-1957</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Bail</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 13 1957

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12444

12437

## CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>W. Va.</u> COUNTY <u>Morgan</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berkeley Springs</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>				STREET ADDRESS (If rural give location) <u>607 S. Washington St.,</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Sheila Gay Younker</u>				4. DATE (Month) (Day) (Year) <u>Nov. 14, 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Infant</u>	8. DATE OF BIRTH <u>II-9-57</u>	9. AGE last birthday yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Berkeley Springs, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thurman L. Younker Jr</u>				14. MOTHER'S MAIDEN NAME <u>Helen Eppinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Thurman L. Younker Jr</u> <u>Berkeley Springs, W. Va.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Intra-cranial Hemorrhage Severe</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Tentorial tears due to</u>				<u>5 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Probable birth injuries</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <u>at work</u> <input type="checkbox"/> <u>Not while at work</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/13/1957</u> , to <u>11/14/1957</u> , that I last saw the deceased alive on <u>11/14/1957</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>D. M. Bacon Jr</u>				ADDRESS (Street, city, town, state) <u>302 N. Potomac St. Hagerstown</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>II-14-57</u>		NAME OF CEMETERY OR CREMATORY <u>Parkhead Cem. Md.</u>		LOCATION (City, town, or county) (State) <u>Rural Hancock, Md.</u>	
24. REC'D BY REGISTRAR <u>NOV</u>		REGISTRAR'S SIGNATURE <u>Chas Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Parkhead Funeral Home</u> <u>Berkeley Spgs. W. Va.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12451

## CERTIFICATE OF DEATH

12445

Reg. Dist. No. 307

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(RURAL) Yarrowsburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(RURAL) YARROWSBURG x2</b>	
c. LENGTH OF STAY IN 1b <b>3 yrs.</b>		d. STREET ADDRESS <b>Weverton Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ORVILLE</b> Middle <b>BURRES</b> Last <b>YOUNKINS</b>		4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 14, 1881</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Repairman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Oliver Melvin Younkings</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Elizabeth Kaetzel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>No</b> (If yes, give branch or dates of service)		16. SOCIAL SECURITY NO. <b>705-10-3022</b>	
17. INFORMANT <b>Mrs. Olive Higdon</b>		18. ADDRESS <b>RFD #1, Box 411, Knoxville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY INSUFFICIENCY</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>3 years.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CARCINOMA OF PROSTATE</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 7, 1957</b> to <b>Nov 6, 1957</b> , that I last saw the deceased alive on <b>Nov 6, 1957</b> , and that death occurred at <b>11:00A</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph C. Crisp</b>		ADDRESS (Street, city or town, state) <b>115 King St., Hagerstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Joseph C. Crisp, 115 King St., Hagerstown, Md.</b>		DATE SIGNED <b>11/29/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/1/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Brethren Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Brownsville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Donald Cackles</b>		24. REC'D BY REGISTRAR DATE <b>Dec 2-1957</b>	
ADDRESS <b>Harpers Ferry, West Va.</b>		24b. REGISTRAR'S SIGNATURE <b>Katharine Lagerblatt</b>	

BUREAU V.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12428

## CERTIFICATE OF DEATH

12446

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>03</u> <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				e. STREET ADDRESS <u>440 Carlton Ave</u>			
3. NAME OF DECEASED (Type or print) <u>HARRY</u> First <u>B.</u> Middle <u>Zimmerman</u> Last				4. DATE OF DEATH <u>November 17</u> 19 <u>57</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>July 16, 1891</u> Yrs. <u>66</u>	
9. AGE (In years last birthday) <u>66</u> Yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter &amp; paper hanger - same</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Greencastle</u>			
13. FATHER'S NAME <u>James Zimmerman</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Palmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-09-2732</u>			
17. INFORMANT <u>Kenneth Zimmerman</u> Address <u>RD 5 Chambersburg, Pa.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>year</u> <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>16 Nov</u> , 19 <u>57</u> , to <u>17 Nov</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>17 Nov</u> , 19 <u>57</u> , and that death occurred at <u>10:50 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>P. Hoachlander</u> M.D. <u>11/5/57</u> PHYSICIAN'S NAME (Type) <u>F. Hoachlander</u> <u>Greencastle, Pa.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/20/57</u>		<u>Cedar Hill</u>		<u>Greencastle, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	
<u>W.E. Minnick - Greencastle, Pa.</u>				<u>Nov. 21, 1957</u>		<u>Blair Bowers</u>	

CERTIFICATE OF DEATH

*[Faint, mostly illegible text from the certificate form, including fields for name, date, and cause of death.]*

BUREAU V. S.

NOV 25 1957

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